PEDIATRIC QUESTIONNAIRE

**Please fill out as thoroughly as possible as this will help us to serve you optimally!

CONFIDENTIAL PATIENT INFORMATION

Childs Name: (First) (Last) (MI)

Parent/Guardian Name(s):

Child SS#: - - DOB: / / Age: Sex: M F

Marital Status: # of children (if any) Occupation:

Street Address: Height ft in

City: State: Zip Weight lbs

Email: Cell phone: - - Other phone: - -

Emergency contact Emergency relation: Emergency phone: - -

How did you hear about us?
(if you were referred by someone please let us know)

Who is your child's primary care physician?:

Date and reason for last doctor visit:

Is your child receiving care from any other health professionals? ☐ Yes ☐ No
If Yes please name them and their specialty:

Race: Ethnicity: ☐ choose not to specify

Preferred language: ☐ English ☐ Spanish ☐ Sign lang ☐ other

Verification question: Mothers maiden name (first) (last)

Please note any significant family medical history:

Please list any drugs/medications/vitamins/herbs/other that your child is taking

HEALTH GOALS FOR YOUR CHILD:

What are your top three health goals for your child?:

1._____
2._____
3._____

What would you like to gain from chiropractic care?

☐ resolve existing condition
☐ overall wellness
☐ both

Have you ever visited a chiropractor? Yes No If yes, what is their name?

What is their specialty? Pain relief physical therapy & rehab nutritional subluxation based other

CURRENT HEALTH CONDITIONS

What health condition (s) bring your child to be evaluated by a chiropractor?

Has your child received care for this condition before? Yes No

- If yes please explain:

When did the condition(s) first begin?

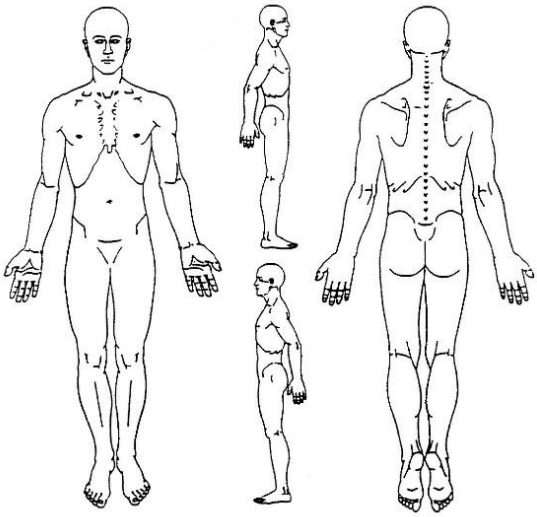
How did the problem start? Suddenly gradually post injury

Is this condition getting worse improving intermittent constant unsure other:

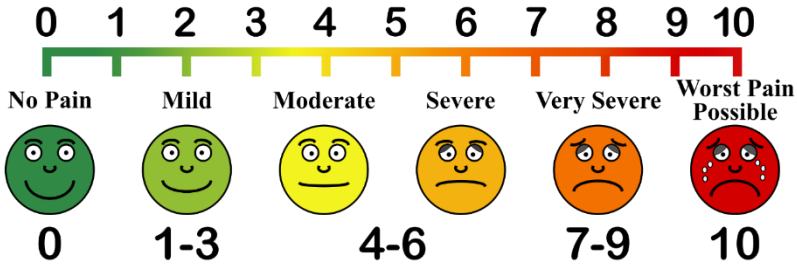
What makes the problem better?:

What makes the problem worse?:

Place an " X " on the drawings to the left wherever you have pain. Mark an "O" for past conditions or issues.



If applicable please rate your pain level(s). Indicate for what region if affected.



PREGNANCY & FERTILITY HISTORY

Please tell us about your pregnancy with the child who is being seen today

Any fertility issues?	Yes	No	If Yes, please explain:
Did mother smoke?	Yes	No	If Yes, how many per week:
Did mother drink ?	Yes	No	If Yes, how many per week:
Did mother exercise?	Yes	No	If Yes, please explain:
Was mother ill?	Yes	No	If Yes, please explain:
Any ultrasounds?	Yes	No	If Yes, please explain:

Please explain any notable episodes of mental or physical stress during your pregnancy:

Please explain any notable concerns or notable remarks about your child's conception or pregnancy:

LABOR & DELIVERY HISTORY

Child's birth was: ☐ Natural vaginal birth ☐ scheduled c section ☐ emergency c section

At how many weeks was your child born?

Child's birth was: ☐ at home ☐ at birthing center ☐ at a hospital ☐ other: Doctor/OB's Name:

Please check any applicable interventions or complications:
☐ Breech ☐ Induction ☐ Pain meds ☐ Epidural ☐ episiotomy ☐ vacuum extraction ☐ forceps ☐ other:

Please describe any other concerns or notable remarks about your child's labor and/or delivery :

Childs birth weight:____lbs _____oz Childs birth height: _____ in APGAR score at birth: APGAR after 5 min:

GROWTH & DEVELOPMENT HISTORY

Is/was your child breastfed? Yes No If yes how long? Difficulty breastfeeding? Yes No

Did they ever use formula? Yes no If yes at what age? If yes what type?

Did/does your child ever suffer from colic, reflux, or constipation as an infant? Yes no
If yes please explain:

Did/does your child frequently arch their neck/back, feel stiff, or bang their head? Yes no

At what age did the child: Respond to sound: _____ Follow an object: _____ Hold their head up: _____ Vocalize: _____
Teethe:_____ Sit alone: _____ Crawl _____ Walk _____ Begin cows milk _____ Begin solid foods _____

Please list anY food intolerance or allergies, and when they began:

Please list your child's hospitalization and surgical history, including the year:

Please list any major injuries, accidents, falls and/or fractures your child has sustained in his/her lifetime, including the year:

Have you chosen to vaccinate your child? ☐ No ☐ yes, on a delayed or selective schedule ☐ yes, on schedule
If yes, please list any vaccination reactions:

Has your child received any antibiotics? Yes No
If yes, how many times and list reason:
Night terrors or difficulty sleeping? Yes No If yes, please explain:

Behavioral, social, or emotional issues Yes No If yes, please explain:

How many hours per day does your child typically spend watching a TV, computer, tablet or phone?

How would you describe your child's diet? ☐ Mostly whole, organic foods ☐ pretty average
☐ high amount of processed foods

*** I certify that the information provided is accurate to the best of my knowledge:**

Today's Date: _____/_____/_____ Printed name of patient: _____

Signature of Patient/legal guardian:_____